Office of Graduate Studies
University of South Florida
Tampa, Florida

CERTIFICATE OF APPROVAL

Master's Thesis

This is to certify that the Master's Thesis of

WANDA FRANCES WILLIS

with a major in Nursing has been approved
for the thesis requirement on April 10, 2000
for the Master of Science degree.

Examining Committee:

Ona Z. Riggin

Major Professor: Ona Z. Riggin, Ed.D., ARNP

Cecile A. Lengacher

Member: Cecile A. Lengacher, Ph.D., RN

Rebecca Sisson

Member: Rebecca Sisson, Ph.D., RN

REPORT DOCUMENTATION PAGE			Form Approved OMB No. 0704-0188

1. AGENCY USE ONLY *(Leave blank)*	2. REPORT DATE	3. REPORT TYPE AND DATES COVERED
	18.Jan.01	THESIS

4. TITLE AND SUBTITLE
THE RELATIONSHIP OF NURSES' INVOLVEMENT AND BELIEFS IN SPIRITUALITY AND THEIR ATTITUDES TOWARD PROVIDING SPIRITUAL CARE

5. FUNDING NUMBERS

6. AUTHOR(S)
MAJ WILLIS WANDA F

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)
UNIVERSITY OF SOUTH FLORIDA

8. PERFORMING ORGANIZATION REPORT NUMBER
CI01-22

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)
THE DEPARTMENT OF THE AIR FORCE
AFIT/CIA, BLDG 125
2950 P STREET
WPAFB OH 45433

10. SPONSORING/MONITORING AGENCY REPORT NUMBER

11. SUPPLEMENTARY NOTES

12a. DISTRIBUTION AVAILABILITY STATEMENT
Unlimited distribution
In Accordance With AFI 35-205/AFIT Sup 1

12b. DISTRIBUTION CODE

13. ABSTRACT *(Maximum 200 words)*

14. SUBJECT TERMS

15. NUMBER OF PAGES
49

16. PRICE CODE

17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT

THE RELATIONSHIP OF NURSES' INVOLVEMENT AND BELIEFS IN SPIRITUALITY AND THEIR ATTITUDES TOWARD PROVIDING SPIRITUAL CARE

by

WANDA FRANCES WILLIS

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science
College of Nursing
University of South Florida

May 2000

Major Professor: Ona Z. Riggin, Ed.D., ARNP

Acknowledgement

I would first like to acknowledge the source of my spiritual well-being, my Lord and Savior Jesus Christ.

I wish to express my deepest gratitude and thanks to Dr. Ona Z. Riggin, my advisor and chairperson, for her guidance, time, support, and expertise. I would also like to thank Dr. Cecile Lengacher and Dr. Rebecca Sisson, my committee members for their encouragement and support and Dr. Jason Beckstead for his statistical support.

I wish to thank my family. To my husband, Arthur Willis Sr., my sons Arthur and Robert thank you for support, encouragement and understanding of the time it has taken to complete this thesis.

I would like to acknowledge my parents, Willie and Rosie Lee Plummer, who always wanted their children to aspire to higher levels of education. Thanks mom and dad.

There are many others who have directly and indirectly assisted me in this educational process, thank you. I would especially like to thank the nursing students who took the time to participate in this study.

Table of Contents

List of Figures

THE RELATIONSHIP OF NURSES' INVOLVEMENT AND BELIEFS IN SPIRITUALITY AND THEIR ATTITUDES TOWARD PROVIDING SPIRITUAL CARE

by

WANDA FRANCES WILLIS

An Abstract

of a thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science
College of Nursing
University of South Florida

May 2000

Major Professor: Ona Z. Riggin, Ed.D., ARNP

The nursing concept of holistic health requires that the nurse care for the whole person. This includes caring for the patient's spiritual needs. It is well documented in the health care literature that a patient's sense of spiritual well-being can have a positive outcome on health care and the quality of life. The illusive nature of spirituality in the provision of nursing care indicates that additional research is needed to better determine its use and application.

A convenience sample of 60 graduate nurses from a university in the Southern United States volunteered for this study. Each subject completed the Health Professional's Spiritual Role Scale and the Spiritual Involvement and Beliefs Scale along with a demographic form

The purpose of this study was to determine if a relationship existed between graduate nursing student's involvement and beliefs in spirituality and their attitudes toward providing spiritual care. Analysis by Pearson Product Moment correlation indicated a statistically significant relationship ($r = .525$, $p = .000$) was present between the relationship of nurse's involvement and beliefs in spirituality and their attitudes toward providing spiritual care. Further analysis of each questionnaire's revealed two distinct components. The Health Professional's Spiritual Role Scale components were health professional role and activities and behaviors. The correlation of these two components was ($r = .671$ $p = .000$). The Spiritual Involvement and Beliefs Scale components were spiritual involvement and Beliefs. The correlation of these two components was ($r = .751$ $p = .000$). A *t*-test analysis of those subjects who attended nursing school associated with an organized religion had a significant finding ($p < .05$) on the activities and behaviors component.

The findings of this study indicated that nurses' involvement and beliefs in spirituality influenced their attitudes toward providing spiritual care. Therefore, the nurses' personal sense of spirituality could directly influence the patient's care.

Abstract Approved: Ona Z. Riggin

Major Professor: Ona Z. Riggin, Ed.D., ARNP
Professor, College of Nursing

Date Approved: April 20, 2000

Chapter I

Introduction

Part of the uniqueness of nursing is that it treats the whole person. This is the meaning of holistic health. Shannon, Wahl, Rhea, and Dyehouse, (1984) view the whole person as having physical, emotional, intellectual, social and spiritual dimensions. Up to this point in the history of health care, all of these arenas have been explored in research in great detail with the exception of spirituality. Since an awareness and significance of the patient's spiritual well-being has become more evident, the health care professional's role relative to providing spiritual care has received increased emphasis. Spirituality is now becoming an area of focus for research.

From a historical viewpoint, spirituality has always been a part of health care. Medicine was originally developed in religious contexts. During the early Christian era, physicians were clergy members, and the church was the first to grant medical licenses. Shamans were the therapists in pre-industrial societies (McKee & Chappel, 1992). In the history of nursing, Florence Nightingale received her first nursing education from the Institution of Deaconesses in Kaiserswerth, Germany (Huxley, 1975).

The 1997 world population was estimated to be over 5,927,000,000 and of which, an estimated 5,848,739,000 adhere to some religion (Famighetti, R., et al., 1997).

Therefore, it is easy to understand why some people think of religion when spirituality is discussed. Organized religion provides a format in which spirituality can be expressed. Regardless of any identified method or form, most individuals have spiritual needs.

It is important to realize that not all forms of spirituality result in a sense of well being or promote harmony. One definition of the root word spirit is an angel or demon (Stein, Hauck, Su, 1980). In an article by Emblen and Halstead (1993) the North American Nursing Diagnoses Association (NANDA) has identified spiritual distress as a nursing diagnosis. The definition of spiritual distress is "a disruption in the life principle which pervades a person's entire being and which integrates and transcends one's biological and psychosocial nature" (as cited by Kim, McFarland, & McLane, 1987, p 55).

Communication and discussion of spirituality is difficult among nurses and between disciplines due to differences in meaning and terminology. There appears to be a consensus in the nursing literature that spirituality is broader than religion. Today, the terms religion, spiritual, and spirituality have a myriad of meanings. Emblen (1992) used the concept analysis model to distinguish the concept of religion from spirituality. The aim was to see how nurses used the terms religion and spirituality. The concern was stated that if these concepts are not clearly defined, there could be difficulty in the delivery of care related to personal life principles, relationships, and transcendent experiences. The review concluded with four definitions for religion. In those definitions, the following words appeared three times: religion, person, and system. These words were found twice: beliefs, organized, practice, and worship. Forty-two other words

appeared once. There were six key words which appeared most frequently: system, beliefs, organized, person, worship, and practice. These words were used to form this theoretical definition: "Systems of organized beliefs and worship which the person practices." (Emblen, 1992, p. 47).

This study found that spirituality had ten definitions with frequency of words broken down in this manner. The word "personal" appeared five times; "life and principle" appeared four times; "animator, being, God or god, quality, relationship and transcendent" each appeared three times. Fifteen other words appeared twice and the 44 remaining words appeared once. The key words were: personal, life, principle, animator, being God (god), quality, relationship, and transcendent. From the combined total of 116 words, only eight common words were found for religion and spiritual. The conclusion of this analysis was that there are major differences in the key words comprising the definition of religion and spiritual, and it may be confusing to interchange the terms. If nurses' have a different meaning for spiritual (spirituality), they cannot communicate clearly about related care. The article concluded "religious care to include helping people maintain their belief systems and worship practices, while spiritual care includes helping people to identify meaning and purpose in their lives, maintain personal relationships, and transcend a given moment" (Emblen, 1992).

Post-White, et al. (1996) gives this definition of spirituality as related by the National Interfaith Coalition on Aging. Spirituality is "Affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness." (as cited in Cook, 1980, p. XIII).

Peck (1978) stated that an extraordinary variability in the breadth and sophistication of our understanding of what life is all about exists among human beings. This understanding is the person's religion. This definition gives religion a very broad meaning that includes more than organized religion. Peck equates religion with world-view.

In providing holistic nursing care, the nurse will encounter patients in spiritual distress. In order to identify and meet the patient's spiritual needs, the nurse's own sense of spiritual well being should be healthy. It can be assumed that if the nurse has some form of spiritual distress, it may be difficult to assess and assist the client who may also be in spiritual distress. Soeken and Carson (1983) identified inadequacy of the nurse's own spiritual resources, or spiritual-well-being as a possible reason for the lack of spiritual care in nursing. Their research showed a correlation between a nurse's spiritual well-being and his/her view of providing spiritual care. The purpose of this study is to determine the relationship of graduate nursing students' involvement and beliefs about spirituality and their attitudes toward providing spiritual care.

Research Questions

The following research questions were examined.

1. Is there a significant relationship between graduate nursing students' involvement and beliefs in spirituality and their attitudes toward providing spiritual care?
2. Is there a significant relationship between the two component's health professional role and activities and behaviors in the Health Professional's Spiritual Role Scale?

3. Is there a significant relationship between the two component's spiritual involvement and spiritual beliefs in The Spiritual Involvement and Beliefs Scale?

Definition of Terms

Spiritual: "the search for meaning in life and a belief in powers greater than oneself" (Shannon, Wahl, Rhea, & Dyehouse, 1984, p 215). Four identified aspects of the patient's spiritual dimension are: a) meaningful philosophy of life; b) sense of numinous and transcendent; c) trusting relationship with God, nature and other people; d) fulfillment of the image of God within self.

Spiritual well-being: a two dimensional concept with vertical and horizontal dimensions. The vertical dimension refers to a personal sense of well-being in relationship to God. The horizontal dimension connotes the perception of life's purpose and satisfaction apart from any specific religious reference (Paloutzian & Ellison, 1982).

Spiritual distress: a disruption in life principles which pervades a person's entire being and which integrates and transcends one's biological and psychosocial nature (as cited by Kim, McFarland, & McLane, 1987, p. 55).

Significance to Nursing

The concept of spirituality is important in the provision of higher level nursing care. In the process of taking care of the whole person, nurses need to be able to identify and feel comfortable with patients in spiritual distress. The nurse's ability to perceive spiritual distress and provide helpful interventions can produce positive outcomes thus enhancing holistic care. Nursing research strongly suggests that there is a positive relationship between a patient's sense of spiritual-well-being and an enriched state of

health. There is a need for more research in order to better understand, educate, and utilize spirituality in nursing practice. More analysis will help in the development of consistent terminology and meaning. When nursing has a clearer understanding of concepts such as spirituality, its communication is facilitated. The dimension of spirituality is a challenging frontier for nursing exploration. There are many questions that are unanswered and many obstacles to overcome. Because spirituality is so broad and individualized, there is much work to be done. It is envisioned that results from this study will add to the body of literature.

Chapter II

Review of the Literature

This chapter presents spirituality as it relates to nursing theorists and their theories. Secondly is the literature research on perceptions and attitudes toward spirituality in health care. In conclusion, a summary will present an overall view of the articles used for this study.

Concept of Spirituality in Nursing Theories

From a theoretical viewpoint, several nurse theorists have provided a framework in which to view spirituality. Nursing theory has two identified world-views, Reciprocal Interaction and Simultaneous Action. Worldview is defined as "a comprehensive conception or image of the universe and of humanity's relation to it" (as cited in Flexner et al. 1993 p. 2160). Martsolf and Mickley (1998) reviewed thirteen nursing theorists and discussed the level of spirituality within their model or theory. These four theorists: Peplau, Orlando, King, and Orem are reported to have little or nothing about spirituality in their models or theory. The concept of spirituality is implied or embedded in the models and conceptual framework of Levine, Johnson, Roy, Leininger and Rogers. It is a central concept in the models of Neuman, Newman, Parse and Watson.

Of the last four theorists with the main concept of spirituality, Neuman and Watson have Reciprocal Interaction worldviews. In contrast, Neuman and Watson, as

well as Newman and Parse have Simultaneous Action worldviews. The nurse's personal worldview and nursing theoretical framework will influence the delivery of health care. The following is a generalized view of the nurse's action as viewed by Martsolf and Mickley (1998) for each worldview in this case study.

> Jane is a 35-year-old mother of two who was diagnosed as HIV positive 3 years ago. She has been able to continue her part-time job as a computer technician but is becoming increasingly fatigued. She describes her appetite as 'poor and has lost 20 pounds in 3 years.' Although they have been using condoms, her husband has recently told her that he does not want to have sex with her any longer because of fear of contagion. She has not told her parents or her teenage children of her diagnosis because she feels that it would 'devastate them.' She often asks, 'Why is this happening to me?' She has come to the clinic with symptoms of a vaginal yeast infection and general concerns about her disease (p.195).

Situational change is evident and expected in the Reciprocal Interaction worldview. The change is reciprocal with the client's environment such as home and work. The overall nursing goal would be to help the client to achieve a stable state in the various dimensions. The goal here might be spiritual wellness. In the Simultaneous Action worldview, the nurse looks for overall patterns of the client interaction with the environment in the form of 'being with' the client (Martsolf and Mickley, 1998). The nurse and the patient enter into a partnership. The nurse would attempt to recognize patterns of interaction between Jane and her family members. Once patterns are validated

by both Jane and the family, the nurse would assist Jane in developing new and higher level patterns or, to transcend old patterns to new ones. Discussion and exploration of the meaning and consequences of Jane's diagnosis with her family will provide help in re-patterning.

Review of Empirical Research

Nurses' attitudes about spiritual care. In their study, Soeken and Carson (1986) listed four possible reasons for the lack of spiritual care in nursing. The first is the biological orientation of nursing to the point that spiritual matters are a cause of discomfort and embarrassment. Another is that nurses believe spiritual issues should be delegated to the chaplain. The third is a deficiency of training to meet spiritual needs, and the last is an inadequacy of the nurse's own spiritual resources, or spiritual well-being. A convenience sample in this study was from a public institution; it consisted of 29 senior-year baccalaureate and 24 graduate nursing students. Average ages were 22 and 29 years respectively. Three participants were men. Nursing experience for the graduate nurses ranged from 2 to 22 years, with a mean of 6.0 years and a median of 4.8 years. A majority (77.3%) of the participants considered themselves members of a religious group: 39.6 % Roman Catholic, 30.2 % Protestant, 7.5 % Jewish. No difference existed between graduate and undergraduate in this respect. Two instruments were used in this study. The Spiritual Well-Being Scale (SWB) developed by Craig Ellison and Raymond Paloutzian was used to measure the nurse's spiritual well-being. This scale measures two dimensions: religious well-being (RWB) and existential well-being (EWB). The RWB measures a sense of well-being in relationship to God and the EWB a sense of purpose in

life and life satisfaction apart from religious reference. The SWB consist of 20 items indicating degrees of agreement, ranging from 1 (strongly disagree) to 6 (strongly agree) with ten items on each of the two sub-scales. The second instrument, the Health Professional's Spiritual Role Scale (HPSR) (Appendix A), was developed by Soeken and Carson (1986) to measure the attitudes toward the role of the health professional in providing spiritual care. It contains 25 attitudinal statements, scored in the same manner as the SWB instrument. The nurse's total mean scores on the SWB and HPSR were as follows: RWB 45.8; EWB 48.7; SWB 94.5 HPSR 105.2. The possible range of scores for RWB and EWB was 10 to 60. On the HPSR, the possible range was 25 to 150. Using the Pearson Correlation Coefficient a statistically significant relationship was identified between measures of spiritual well-being and attitude toward spiritual roles. Respondents with higher levels of spiritual well-being expressed a more positive attitude toward providing spiritual care. This suggests that students who felt more positively about their purpose in life and their relation to God also felt more positively about providing spiritual care.

A survey of cancer nurses was conducted to explore spiritual care attitudes, beliefs and practices (Taylor, Highfield, & Amenta, 1994). The sample for this study came from a stratified random sample of 700 questionnaires mailed out to members of the Oncology Nursing Society. The instrument, the Oncology Nurse Spiritual Care Perspective Survey (ONSCPS), is a 13 Likert scale items and two essay questions. Theoretically similar items were clustered together in a sub-scale for the purpose of statistical analysis. Cronbach's alpha coefficient for this sub-scale was 0.79, but internal consistency for the

entire scale was weak at alpha 0.70. The ONSCPS received content validation from a panel of three experienced nurse researchers as well as three investigators and an unknown number of members of the Oncology Nursing Society (ONS) Special Interest Group Committee. The questionnaire was pilot-tested on two nurse clinicians. There was a 35% response rate of 181 nurses returning completed questionnaires. Participants viewed spirituality as a moderately significant element in patients' lives and spiritual care as an important part of nursing. There was a moderately positive response to the question relative to whether the nurse should wait for the patient to raise spiritual concerns. There was a moderately negative response about how freely the nurse should share personal beliefs. They strongly agreed that relationships with others were important to the spiritual health of their patients, but not as sure of whether spiritual health required belief in a deity or higher power. Many responded that it was inappropriate to judge a patient's spirituality based on a belief in a deity, and ten participants did not respond to the item asking if atheists and agnostics could be spiritually healthy.

Nurses' Recognition of Spiritual Needs. In a study by Highfield and Cason's (1983), the objectives were to answer three questions: can nurses recognize signs of spiritual health; can nurses identify signs of spiritual problems; and are nurses aware that spiritual problems do occur in patients? The instrument used in this study was a forty-nine item questionnaire constructed from nursing and pastoral literature. A panel of theology and psychology experts assisted in the development of the questionnaire. Clinebell's framework of religious existential needs was the basis for questions in this instrument. Four spiritual needs were defined and identified. These four needs were:

meaning and purpose in life; need to give love; need to receive love; and need for hope and creativity. All questions were either behaviors or conditions observed in patients and were represented by one of the four spiritual needs. After a pilot study was conducted, the questionnaire was used in this study. Questionnaires were distributed to 100 oncology nurses practicing on surgical floors in a 1,200-bed private hospital. The nurses were instructed to respond to the questions in relation to patients in their care who met the following conditions: 1) recently diagnosed as having some form of cancer; 2) had poor prognosis with short projected live span, and; 3) had been informed of this diagnosis and prognosis. The patient's behavior or conditions were to be identified as either a psychosocial or spiritual dimension. Thirty-five nurses responded to the questionnaire. They consisted of 20% licensed vocational nurses and 80% registered nurses. The participant's average age was 32 and average length of practice was 10 years. All but one of the respondents claimed some religious affiliation.

In respect to the nurse's response to spiritual health, the questions on fulfillment of the need for meaning and purpose in life were divided between spiritual (44%) or psychosocial (42%). Only the need to receive love was identified as a spiritual dimension. This appears to be related to specific religious references in the questions. Over 50% identified fulfillment of the need to give love and for hope and creativity as psychosocial. These findings related to awareness of spiritual health, indicated that nurses associated most signs of spiritual health as the same or part of psychosocial health (Highfield & Cason 1983).

Awareness of spiritual problems was determined by examining their responses to 31 behaviors or conditions, indicating that the patient's spiritual needs were not met. Nurses recognized only five of the 31 items as spiritual in nature. Four of the five items had direct references to God or religion and the fifth questioned the meaning in suffering and death. The remaining items were listed in the psychosocial dimension.

Nurses' recognition of spiritual problems was determined in two ways. The first was by how frequently they thought their patients exhibited problem behaviors and conditions and the second by identification of problem behaviors and conditions as patient problems. Sixteen of the items were indicated as occurring frequently and 15 as occurring infrequently. Less than one-third of the items indicating spiritual problems were recognized by the 26 (74%) responding nurses. These overall results indicated a limited ability of these nurses to identify the spiritual dimension of patients' behaviors and conditions (Highfield & Cason's 1983).

Comparing Patients, Nurses and Chaplains Views of Spiritual Needs. Emblen and Halstead's (1993) study was designed to gather perspectives from patients, nurses and chaplains to identify and compare each group's meaning regarding spiritual needs and interventions. A convenience sample of surgical patients meeting these criteria was selected: 1) not a cardiac or liver transplant; 2) sufficiently alert to reflect on and respond to questions; 3) English speaking adult over 18, and; 4) not in discomfort that would impede speech. The researcher referred to kardex files, then approached patients to ask for their willingness to participate and their written consent. Chaplains were selected from general and affiliated hospitals. Nurses in a general hospital setting were

interviewed until no new information was added, and then additional nurses from a religiously affiliated hospital were interviewed with little new information reported. Similar approaches to those used with the patients were used to obtain participation from the nurses and chaplains. All interviews were tape-recorded and transcribed. Nineteen patients were interviewed; seven males and 12 females, with their ages ranging from 27 to 75. There were 12 nurses; 11 female and 1 male. Years of nursing practice ranged from 1 to 27 years with a mean of 10.25 years. Seven chaplains participated; two females and five males. Their years of practice ranged from 2 months to 19 years with a mean of eight years.

Emblen and Halstead's (1993) used procedures established by Stallwood and Stoll (1975), Stoll (1979) and Colliton (1981) in preparation of the question items for this study. An expert panel of two chaplains and two nurse researchers established validity of the research questions. In the interview of the patients; some were more verbal than others. If they had difficulties responding, the interviewer would rephrase the question. Nurses and chaplains had few questions and answered promptly. Average time for interviews was 20 minutes for patients, 15 minutes for nurses and 40 minutes for chaplains. The time frames varied depending upon participant's ability to articulate knowledge and valuation of spiritual issues. Patients with firm religious views wanted to speak longer. Nurses with strong religious beliefs, or had interacted with patients with strong religious beliefs, usually associated spiritual needs with religious concerns. All the interviewed chaplains highly valued the spiritual aspect and spoke extensively of their personal or professional experiences in working with patients dealing with religious and

spiritual matters. Emblen and Halstead's (1993) developed categories as described by Knafl & Howard (1984). Transcripts were reviewed and coding categories were developed that reflected items discussed in the interview. Identified categories with definitions from the context of the interviews were given to another coder, who then coded the transcripts. Intercoder agreement was reported to be 100%. No additional information is given about the validity and reliability of this study.

All three groups identified classification of spiritual needs under six headings: religious, relationships, affective feeling, transcendence, values and communication. Limitations identified by the authors include patient age, type of patient, and religious orientation. Male patients were more hesitant and gave brief answers during the interview. It was also suggested that if nurses and chaplains respond to patients' spiritual needs from their personal point of view, their interventions might not meet the patients' needs (Emblen & Halstead, 1993).

Medical Student and Patient Attitudes toward Religion and Spirituality. A study by Goldfarb, Galanter, McDowell, Lifeshultz and Dermatis (1996) compared the assessment of medical students to dually diagnosed (DD) patients. Dually diagnosed patients are those with both a substance disorder and a primary psychological condition. The samples of 119 medical students in this study came from 160 first and second year students asked to volunteer as participants. The mean age of the students was 23.5 years with 72 (61%) being male. The 101 patients were selected from the first 117 consecutive patients admitted to an acute-care dually diagnosed inpatient unit at Bellevue Hospital.

Sixteen patients were eliminated due to inability to complete the study. Patient mean age was 36.7 years with 77 (76%) being male.

Both groups were tested in three areas. They included an orientation toward religion and spirituality, perception of the importance of spirituality in substance abuse treatment, and perceptions of needed improvement on a dually diagnosed unit. The instrument used to measure orientation toward religion and spirituality was a rewritten and edited format of Feagin's original "Orientation to Life and God Scale." The rewritten and edited format underwent assessment for construct validity, and factor analysis. Factor analysis on the 12 items was done separately on the both groups. A factor similarity index (FSI) was computed to assess the extent in which factor loading obtained in the student sample were similar to those in the patient sample. The FSI was 0.95 revealing a significant correlation. The internal consistency (Cronbach's alpha) of 0.86 was identical in both groups. When questioned about religious beliefs, the outcome indicated a higher religious commitment among the patients than the medical students had. The question, "God or a Universal Spirit is a heavenly father who can be reached by prayer." (Goldfarb, et al., 1996) yielded a positive response of 31 (26.1%) from the students and 69 (75.6%) from the patients. The responses between the two groups differed significantly ([X.sup.2] =50.9, df = 4, $p < 0.001$). The perception of the importance of spirituality in substance abuse treatment was tested using an 11-item five-point Likert type scale. The questions asked patients to rate the importance of certain socioeconomic and health services factors to their recovery. The students were asked their perception of what the patients would rank as most important in recovery, using the same

questions. No information is given on the development, validity, or reliability of these questions. The response of the two groups differed significantly on all items except housing and a job. The students indicated that all other items (except government benefits) were less important to patients' treatment than the patients themselves. Fifty-nine patients (59%) ranked "God" number 1, 2, or 3 in importance, whereas 10 students (8%) ranked "God" as 1, 2, or 3. In fact 47 students (39%) ranked "God" as one of the three lowest choices.

The last part measured the group's perception of needed improvement on the unit. Patients were asked "How important would it be to you if the staff improved each of these services?" On a Likert-type scale participants rated services such as: more groups focused on spirituality, more access to religious services, better food, nicer rooms, more contact with doctors and more movies/videos/entertainment. No information is given on the testing or development of these questions. The students' question was "What do you feel the patients would say is the importance of each of these factors in helping them in their recovery?" then given the same six items as the patients. The results were that 74 students (62%) ranked better food as numbers 1 or 2, and 60 patients (60%) ranked more groups focused on spiritually as numbers 1 or 2 Goldfarb, et al. (1996).

Limitations of this study are stated to be its generalizability, and the assessment of perceptions of the importance of improving services. The service stating more groups on spirituality only included group therapy. Patients would have responded as a desire for more general group sessions. Using results from two Gallup poles, a generalization was made that "the patients rather than the medical students possess views of spirituality and

religion that are more representative of the views of the American population as a whole." This suggested that perhaps more emphasis should be placed on spirituality in the medical student's curriculum (Goldfarb, et al, 1996).

The Spiritual Involvement and Beliefs Scale

The Spiritual Involvement and Beliefs Scale (SIBS) (Appendix B) was developed by Hatch, Burg, Naberhaus, and Hellmich, (1998). They acknowledge that there is an overlap between spiritual and religion but the two are not the same. Spirit is defined as that aspect or essence of a person (soul) that gives him or her power and energy, and motivates the pursuit of virtues such as love, truth and wisdom. It is also stated that spirituality is broader than religiosity, and it is possible for an individual to be spiritual and yet not be religious. The attempt of this instrument was two fold. The first was to provide a credible quantitative method of inquiry into a client's spirituality. The second was to have an objective measurement method to facilitate scientific study. Another reason was to develop an instrument to be more inclusive of other religions not just Judeo-Christian. This instrument has gone through several drafts, re-writes, testing, and re-testing. It has been compared to similar instruments, gone through two different correlation studies and considered a valid instrument.

One of the most important aspects of the SIBS was the attempt to balance beliefs and actions. Actions are important, because if there is a belief but no actions what does that say about the level or conviction of the belief? The SIBS was administered to 83 participants, 50 were patients from a rural family practice and 33 professionals who attended a workshop on the development of the SIBS. The test was then re-tested seven to

nine months later. The end result was 22 of the 44 rural patients and 14 of the professionals returned the re-test making it a 60% overall response rate. The final product was a 26-item questionnaire in a modified Likert-type format. A summary of the factor analysis indicates four aspects of spirituality from the questionnaire. The factors were named F1-External/Ritual; F2-Internal/Fluid; F3-Existential/Meditative; and F4-Humility/Personal Application. Items 4 and 18 were deleted due to limited contribution to the instrument. This brought the final correlation of the final score on the SIBS with the Spiritual Well-Being Scale (SWBS) to .80, the test re-test correlation remained .92, and the coefficient alpha reliability coefficient remained .92 (Hatch, Burg, Naberhaus, & Hellmich, 1998).

Summary

The review of literature has addressed different aspects of spirituality. There is a need for clarity of terms related to spirituality as well as a definition that includes but is broader than religion. The reviewed literature acknowledges spiritual well-being in a positive aspect of health. Peck's (1978) expansive definition of religion is much more than an organized religion. It includes our understanding of what life is all about, or in other words, our world view. Our world-view directs the way in which we live, it determines how we interact with our environment, treat others, and ourselves.

Some nursing theorists have accounted for the concept of spirituality within their models or theory. These theories are helpful, but very broad. It is easy to realize that despite some understanding and awareness of spirituality in health care, there is much more that needs to be studied, researched and explored.

The empirical data gives much to consider in the on-going quest for a better understanding and utilization of spirituality in health care. Three of the factors cited by Soeken and Carson, (1986) are touched upon throughout the empirical data as to the lack of attention to spirituality. The first factor, deficiency of training to meet spiritual needs, was indicated to be a possible problem in the comparison of attitudes between medical students and dually diagnosed patients (Goldfarb et al., 1996). There was a significant difference in what the students and the patients considered to be important in recovery. A second factor, inadequacy of person spiritual resources, was also a consideration with the medical students. This was determined by a generalization of two Gallup pole results on religion. A 1990 Gallup pole reported that 94% of Americans indicated a belief in God or a Universal Spirit (one of the questions in the study). The dually diagnosed patients responded with 97% and the medical students responded with 73% to this same question. Likewise, the question, 'God is a Heavenly Father who can be reached by prayer' was responded to by 84% of the American (Gallup pole result); the dually diagnosed patients had a 75.6% response and the students had a 21% response. The implication of Soeken and Carson's (1986) study indicated that a positive correlation was demonstrated between the spiritual well-being of nursing student and their perception of the health professionals' role in spiritual care.

The degree of enlightenment and limited research into spirituality is perhaps due to its intangible quality. It will probably be sometime before nursing and other disciplines

agree upon effective ways to meet spiritual needs. One point to start in meeting this challenge is for health care providers to have their own spirituality in a state of well-being.

Chapter III

Methods

This chapter provides the information on the research methods used in this study. The sample population and the instruments are described. The procedure used in the administration of the instruments and the analysis of the data is explained.

Sample

A convenience sample of 60 registered nurses participated in this study. Criteria for inclusion were: (a) 25 years of age or older; (b) a minimal of two years of nursing experience; and (c) willingness to participate in the study. The participants were graduate nursing students enrolled at a college of nursing in the Southeastern United States.

Instrumentation

Health Professional's Spiritual Role Scale. Soeken and Carson (1986) developed the Health Professional's Spiritual Role Scale (HPSR) (Appendix A). The scale is a 25-item Likert scale to assess attitudes toward the role of health professionals in providing spiritual care. The scale contains two components: health professional role, and activities and behaviors. The first 25 items makeup the first component, health professional role. It is scored on a 1-6-point scale with the higher score reflecting a more positive attitude. The second component, activities and behaviors, contains 13-items which are to be considered appropriate or not appropriate actions or behaviors in giving spiritual care.

Subjects are asked to indicate the appropriateness of the behavior on a 1-4-point scale with the higher number indicating appropriate behavior. The scale was developed from a review of the nursing literature on the spiritual dimension of nursing practice. Negatively and positively stated word items were used to avoid potential bias. Two nursing instructors of spirituality in nursing practice reviewed the items for content. The HPSR scale correlated positively with Paloutzian and Ellison's Spiritual Well-Being Scale (r = .43, n = 53); (r = .57, n = 93) and the correlation with the Religious Well-Being Subscale was (r = .46; n = 53).

Test-retest reliability resulted in (r = .84) in a sample of 29 graduate nursing students tested at a two week interval. The internal consistency reliability measured by coefficient alpha for the attitude statements was tested in these three situations: a) Testing with 53 nursing students, 29 senior year and 24 graduate (r = .79). b) A sample of 93 registered nurses from two teaching hospitals and one community hospital yielded (r = .81). c) Twenty-one graduate nursing students tested twice yielded scores of (r = .75) and (r = .78).

The Spiritual Involvement and Beliefs Scale. The Spiritual Involvement and Beliefs Scale, (SIBS) (Appendix B) developed by Hatch and colleagues (1998), was used to measure spiritual well-being. The instrument contains 26 items in a modified Likert-type format. This scale also contains two components, spiritual involvement and spiritual beliefs. The first component, spiritual beliefs, contains 19-items. The second component, spiritual involvement, contains seven items. The scale was designed to be widely applicable across religious traditions. The instrument measures assessment of actions as

well as beliefs. The instrument's developers hypothesized that an individual's actions are important indicators of their spiritual status and that actions might be more important than their beliefs.

Concurrent construct validity was determined by correlating total scores on the SIBS with total scores on the Spiritual Well Being Scale (SWBS). The internal consistency of the SIBS was assessed using Cronbach's alpha and resulted in an overall coefficient alpha of .92. Test-retest reliability yielded a coefficient of stability of .92 based on 29 usable pairs of tests. Convergent construct reliability was assessed by comparing total scores from SIBS and SWBS; this yielded a reliability coefficient of .80. An orthogonal factor analysis of the instrument items using a varimax rotation yielded a six-factor structure. Two factors were eliminated due to low eigenvalues. The results of this analysis yielded a clear four-factor structure. The factors are: F1- External/Ritual; F2 – Internal/Fluid; F3 – Existential/Meditative; F4 – Humility/Personal Application.

Demographic form. Demographic data (Appendix C) was collected to describe the sample. Data included gender, age, nursing specialty, educational experience and level, years in nursing and number of years in specialty; whether the school attended was private or public; whether the nursing students had received instructions in spirituality; and whether the nursing students desired additional instruction in spirituality.

Procedures

Institutional Review Board. Permission to survey the graduate nursing students was obtained from the Dean of Nursing. Approval to conduct the study was obtained from the University of South Florida Institutional Review Board.

Nursing students were contacted in class. A short explanation of the study was provided and students were asked to participate. Participants were given a letter of participation (Appendix D), their consent being acknowledged with the completion of the questionnaires. Students were asked to complete the HPSRS, SIBS and demographic sheets. Questionnaires were collected immediately after they were completed.

Data Analysis

Information obtained on the demographic data form was collated and reported using descriptive statistics to describe the sample. The following research questions were analyzed.

1. Is there a significant relationship between graduate nursing students' involvement and beliefs in spirituality and their attitudes toward providing spiritual care?
2. Is there a significant relationship between the two components, health professional role and activities and behaviors, in the Health Professional's Spiritual Role Scale?
3. Is there a significant relationship between the two components, spiritual involvement and spiritual beliefs, in The Spiritual Involvement and Beliefs Scale?

Pearson Product Moment Correlation coefficient was used to calculate the significance of the relationship between nurses' involvement and beliefs in spirituality, and their attitudes toward providing spiritual care for the first research question. Means

and standard deviations were computed and Pearson Product Moment correlation coefficient was calculated to determine the relationships between the components of each questionnaire. The components were: health professional role, and activities and behaviors, in the Health Professional's Spiritual Role Scale and spiritual involvement and spiritual beliefs, in The Spiritual Involvement and Beliefs Scale.

Chapter IV

Results, Discussion and Conclusions

This chapter reports the results of the study, discussion of the findings and conclusions. Implications for nursing practice and further research are discussed.

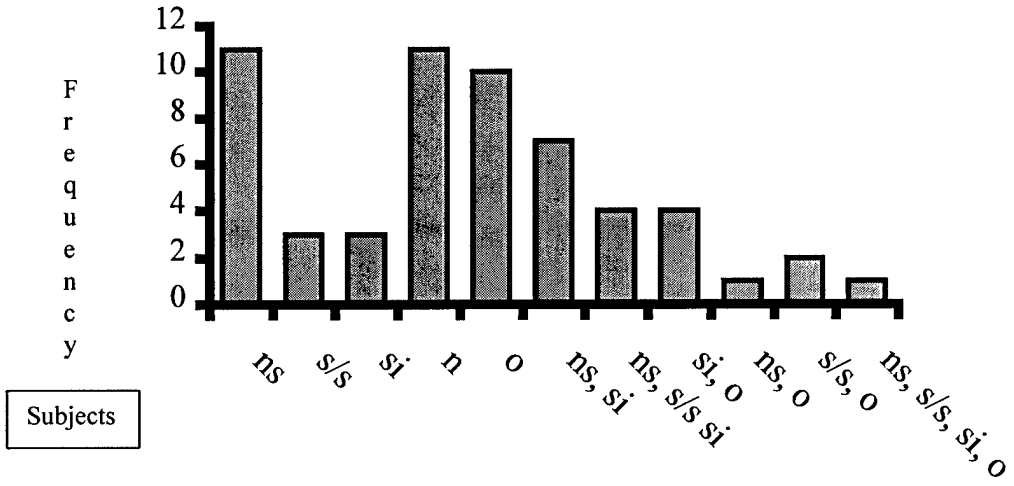
Results

Sample. Descriptive statistics were used to describe the sample. The sample was comprised of 60 subjects, 48 female (80.0%) and ten male (16.7%) graduate nursing students, currently enrolled at the University of South Florida. The age ranged from 25 to 55 years with a mean age of 40.7 years, and a standard deviation (SD) of 7.80. Nine subjects had missing data on various questions. No pattern was noted in the missing data.

Clinical specialties of the subjects were as follows: Adult Health Nursing, 20 (33.5%); Family Health Nursing, 12 (20.0%); Psychiatric Mental Health Nursing, 10 (16.7%); Oncology Nursing, 4 (6.7%); Pediatric Nursing, 3 (5.0%) Administration, 2 (3.3%) and the other 7 (11.7%) were a combination of two or more of these specialties. The subjects had a mean of 12.16 years of nursing practice with a SD of 5.7. The post-secondary education mean was 3.8 with a SD of 2.9. Other data revealed that only nine (15.0%) attended nursing schools with religious association.

Sources of spiritual education were as follows: 11 (18.3%) nursing school (ns); 3 (5.0%) seminar/symposiums (s/s); 3 (5.0%) self-instruction (si); 11 (18.3%) none (n); 10 (16.7%) other (o). The subjects also listed combinations of sources. Alcoholic's Anonymous, 12 step groups, church, and families were sources of 'other' written on the data sheet.

Figure 1. *Sources of Spiritual Education*



Research Questions. The first question: Is there a significant relationship between graduate nursing students' involvement and beliefs in spirituality and their attitudes toward providing spiritual care? The two instruments, Health Professional's Spiritual Role Scale and the Spiritual Involvement and Beliefs Scale, indicated a significant relationship using the Pearson Product Moment correlation ($r = .525$, $p = .000$).

The second question: Is there a significant relationship between the two components of health professional role and activities and behaviors in the Health

Professional Spiritual Role Scale? The professional spiritual role contains 25 questions with a possible range of 25 to 130. Actual score ranged from 65 to 130 with a mean of 102.0 and SD of 14.1. Internal reliability yielded Cronbach's alpha coefficient of .87. The second component of the scale included the activities and behaviors with 13 questions. The possible scores range was 13 to 52. Actual scores ranged from 22 to 52 with a mean of 39.8 and SD of 7.0. Cronbach's alpha coefficient yielded .85. Pearson Product Moment correlation between these two components was ($r = .671$, $p = .000$).

The third question: Is there a significant relationship between the two component's spiritual involvement and spiritual beliefs in The Spiritual Involvement and Beliefs Scale? The first 19-questions, spiritual beliefs, had a possible range of 19 to 95. Actual scores ranged from 32 to 95 with a mean of 77.6 and SD of 12.4. Cronbach's alpha coefficient yielded .91. The second component, spiritual involvement, contains seven questions with a possible range of zero to four. Actual scores ranged from 8 to 27 with a mean of 16.3 and SD of 4.0. The reliability Cronbach alpha coefficient was .62. Pearson correlation of professional spiritual role and activities and behaviors was ($r = .751$, $p = .000$).

Discussion

Sample. The mean age of subjects was 40.7 years, the maturity of the subjects could account for the positive attitude toward providing spiritual care to patients. Further analysis of the data revealed that subjects who attended a nursing school associated with organized religion 9 (15.0%) had higher scores. The mean score on the HPSRS for these 9 subjects (15.0%) was 153.33 and the mean score on the HPSRS for the other 48 subjects was 140.47. The mean score on the SIBS for these 9 subjects was 94.66 and the

mean score on the SIBS for the 48 subjects was 93.25. These nine subjects had mean scores that were higher on all four components than subjects who did not attend nursing schools associated with an organized religion. A *t-test* analysis of the activities and behaviors component of the HPSRS revealed that this sub-group had a significant finding ($p < 0.05$).

Question #10 asked whether the subjects would like more instruction and question #11 inquired about the opposite, i.e. "I do not need any instruction on caring for the patient's spiritual needs." Thirty-nine (65%) answered positively to the desire for more instruction on caring for patient's spiritual needs. Forty-three (71.7%) gave a negative response to "I do not need any instruction on caring for the patient's spiritual needs." The results of these two questions demonstrated consistency in the subject's responses. Analysis of the data by *t-test* indicated that those subjects who desired more instructions on spiritual care had significant findings ($p < 0.05$) on all four components of the questionnaires. At least 24 (40%) of the subjects identified nursing schools as a primary source of education of spiritual care.

Research Questions. The relationship between the two instruments HPSRS and SIBS indicated positive correlation Pearson Product Moment coefficient ($r = .525$, $p = .000$) between professional spiritual role, activities and behaviors, and the nurse's spiritual involvement and beliefs. This revealed that there was a significant relationship between graduate nursing students' involvement and beliefs in spirituality and their attitudes toward providing spiritual care.

The Spiritual Involvement and Beliefs Scale was developed in 1998, no other use of these two instruments, after their development, was noted in the literature review. The present research appears to be the first time that HPSRS or the SIBS were used in a research study and the first time that the instruments were investigated. Important aspects of this correlation were the reported consistency in the nurses' spiritual involvement and beliefs as well as their attitudes toward spiritual roles and activities. Individuals can have attitudes that do not match their actions. In the literature review Soeken and Carson (1986) noted a study by Rhonda Chadwick, RN in which nurses reported being comfortable praying or reading the Bible to a patient, but 25% had not done either.

The second research question investigated whether there was a relationship between the two components health professional role and activities and behaviors in the Health Professional's Spiritual Role Scale. Findings using a Pearson correlation revealed ($r = .671$, $p = .000$).

The first component, health professional role, had a mean of 102.0 this was similar to Soeken and Carson (1986) mean of 105.2. Questions in this component related to spiritual roles in providing health care and judgements about spiritual roles.

Subjects indicated activities and behaviors, the second component, to be very appropriate. Likewise on the mean rating of appropriateness of behaviors and activities Soeken and Carson (1986) reported means of 2.17 to 3.98. In this study the mean rating of appropriateness of behavior and activities produced means ranging from 2.06 to 3.96. Showing kindness and concern (question #5) to a patient was rated most appropriate in both of these studies.

The third research question investigated whether there was a relationship between the two components spiritual involvement and spiritual beliefs in The Spiritual Involvement and Beliefs Scale. Findings indicated a significant relationship at ($r = .751$, $p = .000$). This indicates a strong correlation between the subject's spiritual involvement and beliefs. The first 19-questions of the 26-item questionnaire had responses that ranged from strongly agree to strongly disagree. Questions #20 through #23 were scored as zero for never and four for always. The last three questions were related to the frequencies in which an activity was performed. Questions #24 and #25 were scored from zero to four, with zero indicating no involvement and four indicating ten or more times. In question #26 the frequency was somewhat higher, zero indicates no involvement and four indicates 15 times or more.

Subjects in this study demonstrated consistency in beliefs and involvement. As an example 15 (25%) of the subjects equally reported praying 4-6 and 10 or more times per week. The subjects noted spiritual participation (question #26) 70% of the time. Hatch, et al. (1998) reported clustering of results for questions #8, #12 and #20 with greater than 90% of responses being at the highest range 4 or 5. In this study questions #8 and #12 resulted in clustering of over 90% for strongly agree and agree responses. Question #20 had a total of 100% for 'always' and 'usually,' with 50% for each response. Additionally questions #1, #5 and #15 had clustering of 81.7% for 'disagree' and 'strongly disagree.' Questions #2 also has 81.7% responses for strongly agree and agree. Questions #7, #11, #14, and #17 had clustering of strongly agree and agree ranging from 80.0% to 88.4% of

the responses. All of these responses indicated that the subjects have a high degree of spiritual involvement and beliefs.

Conclusions

The review of the literature has indicated that spiritual well-being is an important aspect in regards to patient care. There are many questions for which there are no answers as to how spirituality influences health. This study has indicated that nurses who scored high on spiritual involvement and beliefs had positive attitudes toward providing spiritual care. There was a significant relationship between the two components on each instrument. This study did not evaluate if or how these nurses demonstrate and apply their positive attitudes in nursing practice. This appears to be an area in which little research has been done.

Recommendations for Future Research. A future research study could include a larger sample with a more diverse population. Replication of this study to compare results of nurses in a spiritual or religious work environment versus nurses in other settings is recommended. Also, sampling nurses in different geographic locations and different clinical specialties is indicated. Additional research could be designed to investigate an educational intervention to determine whether a structured intervention would alter the relationship between spiritual involvement and beliefs and attitudes toward providing spiritual care.

References

Colliton, M. A. (1981). The spiritual dimension of nursing. In I. L. Beland & J. Y. Passos (Eds.) *Clinical nursing* (4th ed., pp. 492-501). New York: MacMillan Publishing.

Cook, T. C. (1980). Preface. In J. A.Thorson, & T. C. Cook (Eds.). *Spiritual well-being of the elderly* (p. XIII). Springfield. IL: Charles C. Thomas.

Emblen, J. D. (1993). Religion and spirituality defined according to current use in nursing literature. *Journal of Professional Nursing, 8* (1), 41-47.

Emblen, J. D & Halstead, L. (1993). Spiritual needs and interventions: Comparing the views of patients, nurses and chaplains. *Clinical Nurse Specialist, 7* (4), 175-182.

Famighetti, R., et al. (1997). *The world almanac and book of facts 1998.* New Jersey: World Almanac Books.

Goldfarb, L. M., Galanter, M., McDowell, D., Lifshutz, H., & Dermatis, H., (1996). Medical student and patient attitudes toward religion and spirituality in the recovery process. *American Journal of Drug and Alcohol Abuse, 22* (4), 549-561.

Hatch, R. L., Burg, M. A., Naberhaus, D. S., & Hellmich, L. K. (1998). The spiritual involvement and belief scale: Development and testing of a new instrument. *Journal of Family Practice, 46* (6), 476-487.

Heighfield, M. F. & Cason, C. (1983). Spiritual needs of patients: Are they recognized? *Cancer Nursing,* (6), 187-192.

Huxley, E. (1975). *Florence Nightingale.* New York: G. P. Putnam's.

Kim, M. J., McFarland, G.K., & McLane, A. M. (Eds.) (1987). *Pocket guide to nursing diagnoses* (2nd ed.). St. Louis: C.V. Mosby.

Knafl, K. A., & Howard, M. J. (1984). Interpreting, reporting and evaluating qualitative research. *Research in Nursing and Health, 7,* 17-24.

Martsolf, D.S. & Mickley, J. R. (1998). The concept of spirituality in nursing theories: Differing world-views and extent of focus. *Journal of Advance Nursing, 27,* 294-303.

McKee, D. & Chappel, J. (1992). Spirituality and medical practice. *Journal of Family Practice, 35* (2), 208-210.

Paloutzian, R. F., & Ellison, C. W. (1982). Loneliness, spiritual-well-being and the quality of life. In L. A. Peplau & D. Perlman (Eds.), *Loneliness: A sourcebook of current theory, research and therapy* (pp. 224-237). New York: John Wiley & Sons Inc.

Peck, M. S. (1978). *The road less traveled: A new psychology of love, traditional values and spiritual growth.* New York: Simon & Schuster.

Post-White, J., Ceronsky, C., Kreitzer, M., Nickelson, K., Drew, D., Mackey, K., Koopmeiners, L., Gutknecht, S. (1996). Hope, spirituality, sense of coherence and quality of life in patients with cancer. *Oncology Nursing Forum, 23* (10), 1571-1579.

Shannon, C., Wahl, P., Rhea, M. & Dyehouse, J. (1984). The nursing process. In C. M. Beck, R. P. Rawlins, & S. R, Williams (Eds.), *Mental health psychiatric nursing: A holistic life-cycle approach.* (pp. 198-236). St. Louis: C. V. Mosby Co.

Soeken, K. L. & Carson, V. J. (1986). Study measures nurses' attitudes about providing spiritual care. *Health Progress,* (3) 52-55.

Stallwood, J. & Stoll, R. (1975). Spiritual dimensions of nursing practice. In I. L. Beland & J. Y. Passos (Eds.). *Clinical Nursing* (3rd ed., pp. 1086-1098). New York: MacMillan-Publishing.

Stein, J., Hauch, L. & Su, P. Y. (Eds.). (1980). *The random house college dictionary* (Rev. ed.). New York: Random House.

Stoll, R. R. (1979). Guidelines for spiritual assessment. *American Journal of Nursing,* 79, 1574-1577.

Taylor, E. J., Highfield, M., & Amenta, M. (1994). Attitudes and beliefs regarding spiritual care. *Cancer Nursing, 17 (6)* 479-487.

Appendices

Appendix A: Health Professional's Spiritual Role Scale

Health Professional's Spiritual Role Scale

For each of the following indicate how much you agree or disagree with the statement. There are no right or wrong answers. We are merely interested in your opinion as reflected by the state. Please circle your response using the following code:

SA = Strongly Agree
MA = Moderately Agree
A = Agree
D = Disagree
MD = Moderately Disagree
SD = Strongly Disagree

1. Health professionals give spiritual care to their patients by being concerned and kind.	SA	MA	A	D	MD	SD
2. A health professional should ask every patient if he/she wants to see a clergyman. (person)	SA	MA	A	D	MD	SD
3. Most health professionals are not qualified to help patients with their spiritual needs.	SA	MA	A	D	MD	SD
4. A patient's religious beliefs are too personal to discuss with a health professional.	SA	MA	A	D	MD	SD
5. Health professionals are too busy to help patients with their spiritual needs.	SA	MA	A	D	MD	SD
6. Health professionals who talk with patients about religious beliefs are trying to convert them.	SA	MA	A	D	MD	SD
7. A health professional who listens to patient concerns and fears is providing spiritual care.	SA	MA	A	D	MD	SD
8. A health professional should have no preconceived ideas about a patient's relationship with God.	SA	MA	A	D	MD	SD
9. Using Scripture with a patient is appropriate for a health professional.	SA	MA	A	D	MD	SD

Appendix A (Continued)

SA = Strongly Agree
MA = Moderately Agree
A = Agree
D = Disagree
MD = Moderately Disagree
SD = Strongly Disagree

10. Offering spiritual assistance to a patient is the clergyman's (person) role and not the health professional's role.	SA	MA	A	D	MD	SD
11. A health professional can assess a patient's spiritual needs by being observant.	SA	MA	A	D	MD	SD
12. Being able to assess a patient's spiritual needs requires special training.	SA	MA	A	D	MD	SD
13. Asking a patient his/her religious preference is sufficient for assessing the spiritual needs of the patient.	SA	MA	A	D	MD	SD
14. Most health professionals are uncomfortable discussing spiritual matters with their patients.	SA	MA	A	D	MD	SD
15. To be able to meet the spiritual needs of patients, a health professional needs to have a strong personal relationship with God.	SA	MA	A	D	MD	SD
16. Most health professionals are aware of the need to assess the spirituality of a patient.	SA	MA	A	D	MD	SD
17. If the health professional knows about a patient's religious values, he/she can offer better physical care.	SA	MA	A	D	MD	SD
18. Offering spiritual assistance to a patient can be the health professional's role as well as the clergyman's (person) role.	SA	MA	A	D	MD	SD
19. A health professional should pray with a patient only if the patient is of the same religious faith.	SA	MA	A	D	MD	SD
20. Many health professionals don't understand how important religion is in the lives of their patients.	SA	MA	A	D	MD	SD

SA = Strongly Agree
MA = Moderately Agree
A = Agree
D = Disagree
MD = Moderately Disagree
SD = Strongly Disagree

21. A health professional needs to be concerned about his/her own spiritual life before meeting the spiritual needs of patients.	SA	MA	A	D	MD	SD
22. The spiritual well-being of a patient is not as important as the physical well-being.	SA	MA	A	D	MD	SD
23. Responding to the spiritual needs of a patient is a responsibility of the health professional.	SA	MA	A	D	MD	SD
24. Understanding a patient's relationship with God is of little importance in providing physical care.	SA	MA	A	D	MD	SD
25. The emotional well-being of a patient is as important as the spiritual well-being.	SA	MA	A	D	MD	SD

Appendix A (Continued)

For each of the following activities or behaviors indicate how appropriate you feel it is for a health professional.

1 = Not appropriate
2 = Somewhat appropriate
3 = Appropriate
4 = Very appropriate

1. Refer patient to the clergy.	1	2	3	4
2. Pray with a patient.	1	2	3	4
3. Talk with a patient about God.	1	2	3	4
4. Read Scripture to a patient.	1	2	3	4
5. Show kindness and concern to a patient.	1	2	3	4
6. Listen to a patient talk about God.	1	2	3	4
7. Talk with a patient about religious beliefs	1	2	3	4
8. Obtain religious material for the patient.	1	2	3	4
9. Assist the patient to carry out religious practices and rituals.	1	2	3	4
10. Encourage the patient to talk about his/her fears and hopes.	1	2	3	4
11. Assure the patient of God's presence.	1	2	3	4
12. Arrange a visit from the clergy.	1	2	3	4
13. Pray for a patient.	1	2	3	4

Appendix B: The Spiritual Involvement and Beliefs Scale

The Spiritual Involvement and Beliefs Scale

Please answer the following questions by checking your response.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. In the future, science will be able to explain everything.					
2. I can find meaning in times of hardship.					
3. A person can be fulfilled without pursuing an active spiritual life.					
4. I am thankful for all that has happened to me.					
5. Spiritual activities have not helped me become closer to other people.					
6. Some experiences can be understood Only through one's spiritual beliefs.					
7. A spiritual force influences the events in my life.					
8. My life has a purpose.					
9. Prayers do not really change what happens.					
10. Participating in spiritual activities helps me forgive other people.					
11. My spiritual beliefs continue to evolve.					
12. I believe there is a power greater than myself.					
13. I probably will not re-examine my spiritual belief					
14. My spiritual life fulfills me in ways that material possessions do not.					
15. Spiritual activities have not helped me develop my identity.					
16. Meditation does not help me feel more in touch with my inner spirit.					
17. I have a personal relationship with a power greater than myself.					
18. I have felt pressured to accept spiritual beliefs that I do not agree with.					
19. Spiritual activities help me draw closer to a power greater than myself.					

	Always	Usually	Sometimes	Rarely	Never
20. When I wrong someone, I make an effort to apology.					
21. When I am ashamed of something I have done, I tell.					
22. I solve my problems without using spiritual resources.					
23. I examine my actions to see if they reflect my values.					
24. During the last WEEK, I prayed... (check one) ------- 10 or more times. ------- 7-9 times. ------- 4-6 times. ------- 1-3 times. ------- 0 times.					
25. During the last WEEK, I meditated (check one) ------- 10 or more times. ------- 7-9 times. ------- 4-6 times. ------- 1-3 times. ------- 0 times.					
26. Last MONTH, I participated in spiritual activities with at least one other person...(check one) ------- More than 15 times. -------11-15 times. -------6-10 times. -------1-5 times. -------0 times.					

Appendix C: Demographic Questionnaire

Demographic Questionnaire

1. Age_____

2. Sex 1. Female 2. Male

3. My clinical specialty is: 1. Adult 2. Pediatric 3. Family 4. Oncology

   5. Psychiatric 6. Administration

4. My years of clinical nursing practice are: _____

5. I have_____ (number of years) in my present specialty.

6. Number of years in post-secondary education_____

7. The nursing school I attended was 1. Private 2. Public

8. The nursing school I attended was associated with an organized religion. Yes No

9. I have received education on spiritual care from:

   1. Nursing school 2. Seminar/Symposiums 3. Self-instructions

   4. None 5. Other_____

10. I would like more instruction on caring for the patient's spiritual needs. Yes No

11. I do not need any instruction on caring for the patient's spiritual needs. Yes No

12. Do you have any professional education or degrees other than nursing? Yes No

---

Appendix D: Letter of Participation

I am requesting your participation in a research study about nurses' levels of spirituality and providing spiritual care.

The purpose of the study is to determine if a relationship exists between nurses' level of spiritual involvement and beliefs and their attitudes toward the health professional's role in providing spiritual care. As a participant you will be asked to complete two questionnaires, i.e. The Spiritual Involvement and Beliefs Scale, The Health Professional's Spiritual Role Scale, and a data sheet.

Participation in this study is on a voluntary basis. You may withdraw from the study at any time. There are no penalties for non-participation or for stopping participation. There are no risks involved in participation. Participation may cause thoughts upon the degree of spirituality in your professional practice. The results of this study may contribute to an increased awareness of spirituality.

If you volunteer to participate, confidentiality and anonymity are assured. The findings will be only reported as group data. Completing the questionnaires and data sheet, indicates consent to participate. It also indicates your understanding of the general purpose of the study, risks and benefits, and that participation is completely voluntary.

Your participation would be greatly appreciated. A copy of the study findings will be made available to you at your request. If you have further questions, please do not hesitate to contact me, Wanda Willis.

Thank you,

_____ _____

Wanda F. Willis, RNC Date

Appendix E: IRB Approval Letter

November 18, 1999

Ona Z. Riggin, Ed.D., A.R.N.P.
Department of Nursing
MDC Box 22
C/O Wanda F. Willis, B.S.N.

Dear Dr. Riggin,

Your new protocol (**IRB #98.721**) entitled,

"The Relationship of Nurses' Involvement and Beliefs in Spirituality and their Attitudes toward Providing Spiritual Care"

has been approved under Exempt Category two (2). This action will be reported at the next convened IRB-02 meeting on December 17, 1999.

If you have any questions regarding this matter please do not hesitate to call my office at 974-5638.

Sincerely,

Barry B Bercu MD

Barry B. Bercu, M.D., Chairperson
USF Institutional Review Board

BBB: amr
cc: FAO

Appendix F: USF Approval Letter

University of South Florida

USF

October 15, 1999

Wanda F. Willis
3608 Cold Creek Dr.
Valrico, FL 33594

Dear Ms. Willis:

I have reviewed your request for permission to survey the graduate nursing students for your research thesis entitled The Relationship of Graduate Nursing Students Level of Spirituality and their Attitude toward the Health Professional's Role in Providing Spiritual Care. You have my permission to survey the graduate nursing students for this purpose. However there are further steps you need to follow before you may proceed with your research.

Please meet with your major advisor, Dr. Ona Riggin, to complete your application for IRB approval of your research project. You must obtain this approval before you can proceed with any research.

I wish you well with your research thesis. It certainly sounds like an interesting and thought-provoking subject.

Sincerely,

Patricia A. Burns, RN, PhD, FAAN
Dean and Professor

C.c: DR. ONA RIGGIN

Appendix G: Health Professional's Spiritual Role Scale Approval Letter

SCHOOL OF NURSING

DEPARTMENT OF EDUCATION,
ADMINISTRATION, HEALTH POLICY
AND INFORMATICS

UNIVERSITY OF MARYLAND

21 June 1999

Wanda Willis
3608 Cold Creek Drive
Valrico, FL 33594

Dear Wanda,

Enclosed is a copy of the Health Professional's Spiritual Role Scale developed and use by Dr. Verna Carson and me in our research. Attached also is information about the scale you might find helpful. You have our permission to use it if you feel it will meet your needs. If you do decide to use the scale, please send me a summary of your findings, especially any findings that related to the reliability and/or validity of the scale.

Based on construction of the items and factor analysis of the scale, the following items need to be reverse scored before a total score is computed for the 25 items: items 3-6, 11-13, 16, 19, 22, and 24. Also, we have found that items 8, 15, and 16 consistently demonstrate low item-to-total correlations although we still believe them to be important items.

I trust your research project will go well. We certainly need more research in the area of the spiritual dimension of nursing care.

Sincerely,

Karen L. Soeken, Ph.D.
Associate Professor

Appendix H: Spiritual Involvement and Beliefs Scale Approval Letter

UNIVERSITY OF FLORIDA

College of Medicine
Department of Community Health and Family Medicine

Health Science Center
PO Box 100222
Gainesville, FL 32610-0222
Tel: (904) 392-4321
Fax: (904) 392-7349

September 2, 1999

Wanda Willis
3608 Cold Creek Dr.
Valrico, Florida 33594

Dear Ms. Willis,

So sorry for the delay in getting back to you. You have my permission to use the Spiritual Involvement and Beliefs Scale in your research. You may use either the initial version, the revised 39 item version, or just a subset of the items if that suits your purposes better.

Good luck with your project!

Sincerely,

Rob Hatch, M.D., M.P.H.